Housing Ohio conference

Medical Respite/Care Coordination Pilot Project

Wednesday, May 8th, 2024


Advocacy
Race Equity
Youth Housing Initiative
OHIO
Balance of State Continuum of Care
COHHIO
Coalition on Homelessness and Housing in Ohio
COHHIO
Training and Technical Assistance
COHHIO
Homeless Management Information System
Housing Ohio conference
SOAR Ohio
Fair Housing & Tenant Information
Healthy Beginnings At Home

BACK TO HEALTH

FORWARD TO HOUSING

JOSEPH & MARY'S HOME

A Ministry of the Sisters of Charity Health System

Every day, hospitals throughout Northeast Ohio discharge hundreds of individuals. Most head home to loved ones and continue their recovery in warm, comfortable environments. Others have no home to head to. Too sick for the streets or shelter and not sick enough to require hospital care, these situations can quickly become a matter of life and death.

Medical respite fills the gap between hospital and home for those who are unhoused and without resources.

Joseph & Mary's Home, a ministry of the Sisters of Charity Health system, is Northeast Ohio's first and only medical respite, offering medically-fragile adults experiencing homelessness the help they need to get back to health and forward to housing.

Medical Respite Care: Definition

Post-acute care for people experiencing homelessness who are too ill or frail to recover from an illness or injury on the street or in shelter, but who do not require hospital level care.

Short-term residential care that allows people an opportunity to rest, recovery, and heal in a safe environment while also accessing clinical care and support services.

Diversity of Programs

- → Bed number
- → Facility type
- → Length of stay
- → Staffing and services
- → Referral sources
- → Admission criteria

Program Models – Core Components

Key Components of all Medical Respite Programs include:

24-hour access to a bed

3 meals per day

Transportation to any/all medical appointments

Access to a phone for telehealth and/or communications related to medical needs

Safe space to store personal items

Wellness check at least 1x every 24 hours by medical respite staff (clinical or non-clinical)

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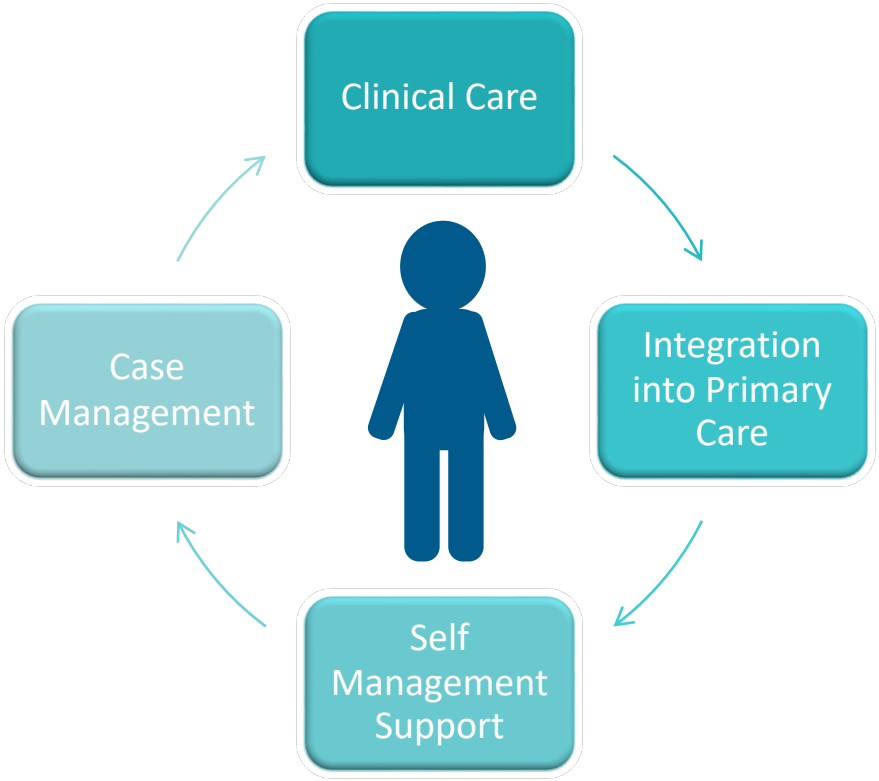
Medical Respite Core Components



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Program Models

Source: Models of Medical Respite Care

Coordinated Care Model	Coordinated Clinical Care Model	Integrated Clinical Care Model	Comprehensive Clinical Care Model
• Case management/ care coordination for medical needs	• Case management/ care coordination for medical needs	• Case management/ care coordination for medical needs	• Case management/ care coordination for medical needs
• Case management/ care coordination for social needs	• Case management/ care coordination for social needs	• Case management/ care coordination for social needs	• Case management/ care coordination for social needs
• Medication support, clients self-manage medication	• Medication management, by clients and licensed clinical staff	• Medication management, by clients and licensed clinical staff	• Medication management by clients and licensed clinical staff
• Client has space to engage with home-based clinical services	• Client has space to engage with home-based clinical services	• Care coordination and space to engage with home-based clinical services	• Care coordination and space to engage with home-based clinical services
• Screen for behavioral health needs and connect to community behavioral health and/or substance use programs (as appropriate)	• Screen for behavioral health needs and connect to community behavioral health and/or substance use resources (as appropriate)	• Behavioral health and/or substance use services through screening, onsite care, and referrals to community partners.	• Behavioral health and/or substance use services through screening, onsite care, and referrals to community partners.
• Connection with community/primary care	• Provision of basic onsite medical clinical services, and connection to community/primary care	• Onsite clinical services, for management of acute and chronic conditions	• Comprehensive onsite clinical services, including management of higher acuity conditions
		• 24-hour program staffing and on-call medical support	• 24-hour program staffing and on-call medical support
		• Connection and transition to primary care provider/health home before discharge	• Connection and transition to primary care provider/health home before discharge
			• Community Health Worker and/or Peer Support as part of staff

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Standards for Medical Respite Care Programs

Standard 1:

- Medical respite program provides safe and quality accommodations.

Standard 2:

- Medical respite program provides quality environmental services.

Standard 3:

- Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings.

Standard 4:

- Medical respite program administers high quality post-acute clinical care.

Standard 5:

- Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services.

Standard 6:

- Medical respite program facilitates safe and appropriate care transitions out of medical respite care.

Standard 7:

- Medical respite care personnel are equipped to address the needs of people experiencing homelessness.

Standard 8:

- Medical respite care is driven by quality improvement.

Framework to support medical respite programs' ability to operate safely, effectively, and seamlessly with local health systems, and to promote program development and growth.

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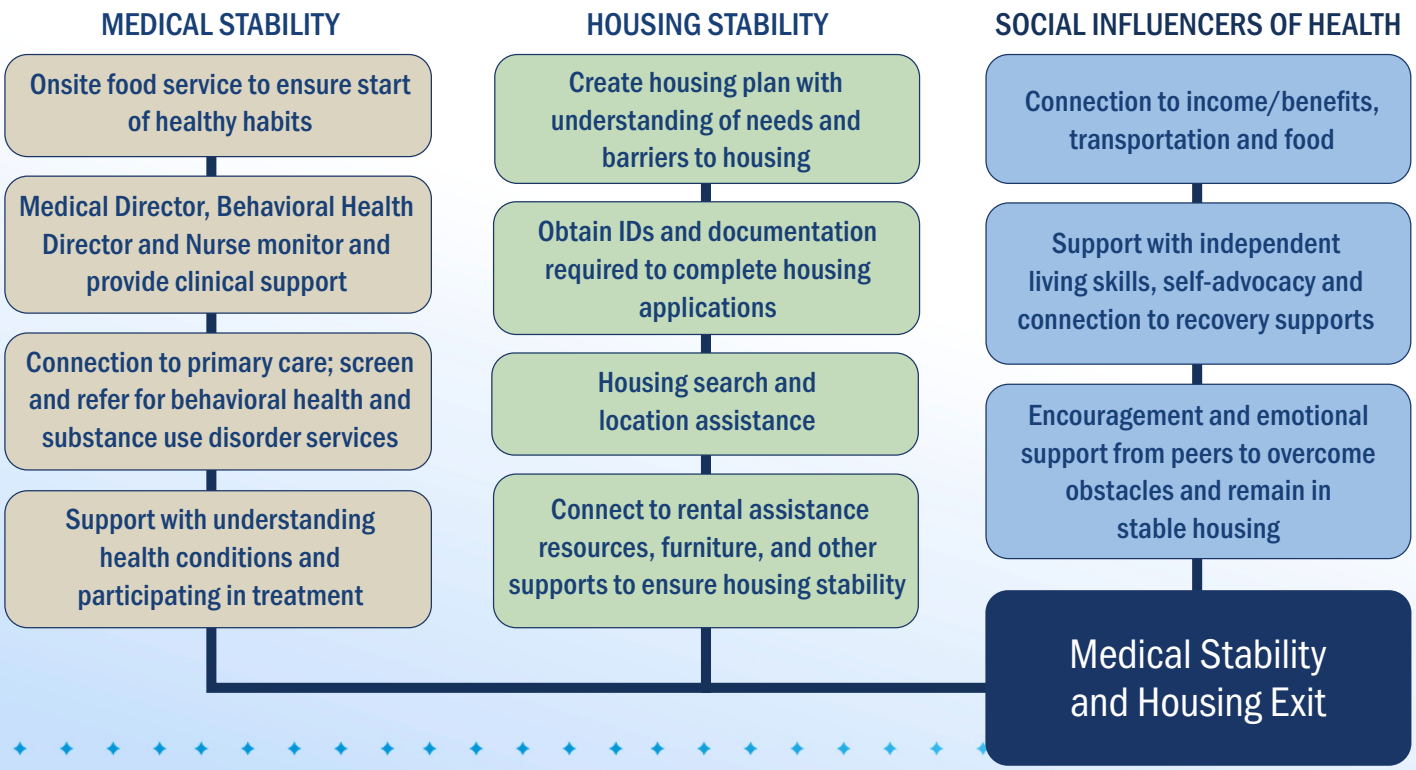
Integrated Care for Medically Fragile Adults



2023 Highlights

- Served more than 140 adults – the most in our history
- 3-year accreditation from Commission on Accreditation of Rehabilitation Facilities (CARF)
- Certification of case management services from Ohio Mental Health and Addiction Services Agency
- Reached 92% fidelity to NIMRC's Standards for Medical Respite Care
- Positive Year-1 results from pilot project with Cleveland Clinic leading to a joint proposal to the National Institutes of Health
- Began silent phase of capital campaign to relocate men's facility (Joseph's Home)

2023 Highlights

Target Population Profile

- 44% female; 56% male
- 61% over the age of 55
- 53% are Black; 12% are Latino
- Average annual income of $10,092
- 90% have a physical disability
- 97% have a chronic health condition
- 83% have a severe mental illness
- 54% have a substance use disorder

Health, Housing & Social Outcomes

- 70% medically stable at exit
- 80% improved their self-care ability
- 80% created a housing plan
- 67% exited to a safe, stable setting
- 87% established or maintained primary care
- 34% referred for behavioral health; 100% of those referred attended their appointment
- 18% increased their cash and/or non-cash income

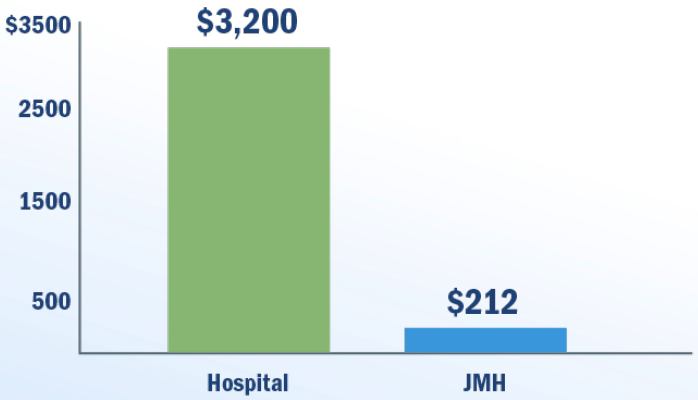
Hospital Cost Savings

Real Impact that is Compassionate and Cost Effective

When someone is hospitalized but has nowhere to rest, recuperate or properly take their medication upon discharge, they stay in the hospital an average of four days longer at an average cost of $3,200 per day. Once discharged, they are also much more likely to need re-admitted.

AVERAGE COST PER DAY

Hospital stay compared to Joseph & Mary's Home



Medical Respite/Care Coordination Pilot

BETH GRAHAM, JOSEPH & MARY'S HOME

KAREN DISTELHORST, CLEVELAND CLINIC HEALTH SYSTEM

CLEVELAND, OHIO

Project Evaluation: Year 1

Methods

- Retrospective medical record review (MH records as primary source of data)
- Use of existing data (intake data; HMIS report; discharge summary report; resident survey)
- Approved by the St Vincent Charity Community Health Center Privacy Board and the Cleveland Clinic IRB in October
- United Way funds allocated for data collection, data management, and statistical analysis with in-kind contribution for proposal development, study coordination, and IRB oversight by Cleveland Clinic.

Data collection and analysis

- Review of referrals (N=125) and resident records (N=40) from March 2022 to May 2023
- JMH provided data files over secure platform in password protected files and chart review data was entered into REDCap (secure online platform)
- Descriptive statistics using a) medians and interquartile ranges (IQR), and b) counts and percentages
- Comparative statistics (between referral sources; between race) using a) Pearson chi-square test, b) Wilcoxon rank sum test, and c) Fishers exact test
- Significance level of 0.05 was assumed

Limitations/Challenges

- Documentation not necessarily designed for research
- Missing data
- Transition from paper to electronic medical records
- Small sample size

Evaluation Aims

1

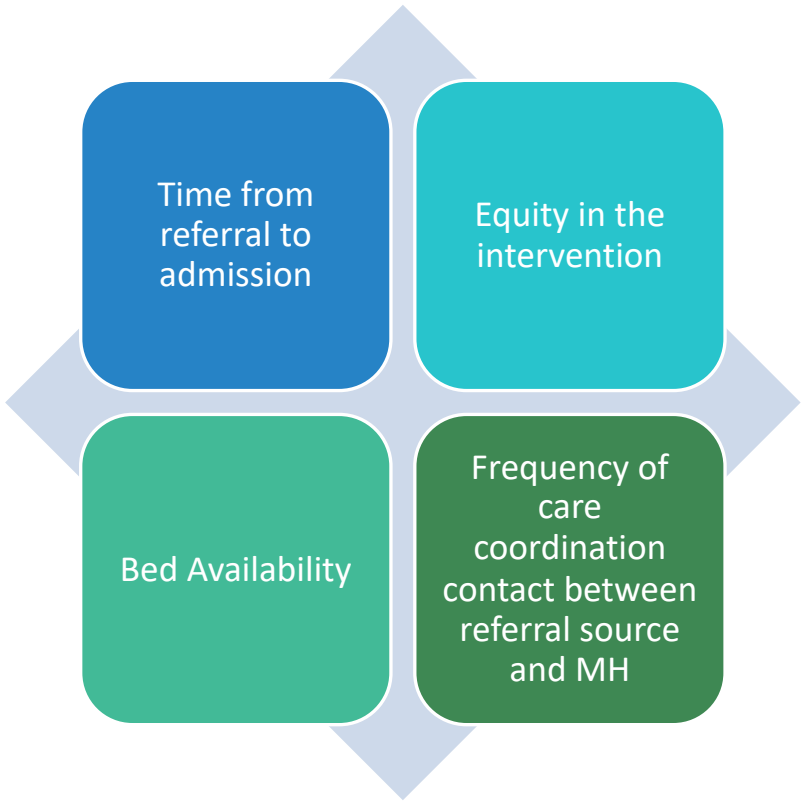
Aim 1: Evaluate the ***process outcomes*** for Mary's Home referrals and transition of care

2

Aim 2: Describe ***resident outcomes*** for homeless women admitted to Mary's Home

3

Aim 3: Describe the ***resident experience*** for homeless women admitted to Mary's Home



Process outcomes

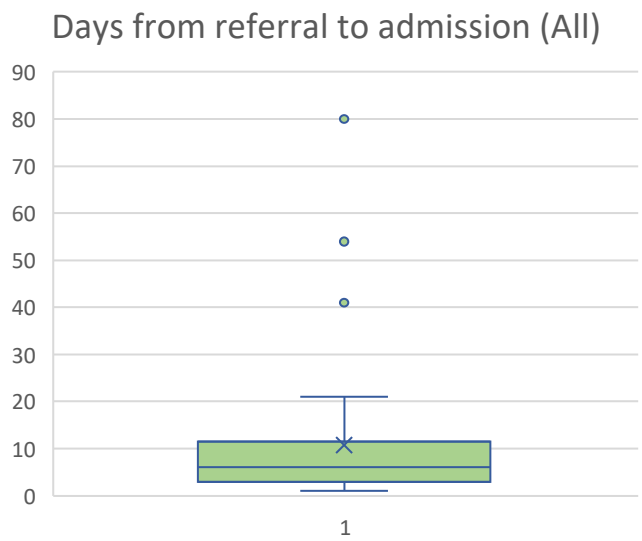
Referrals (March 2022 – May 2023)

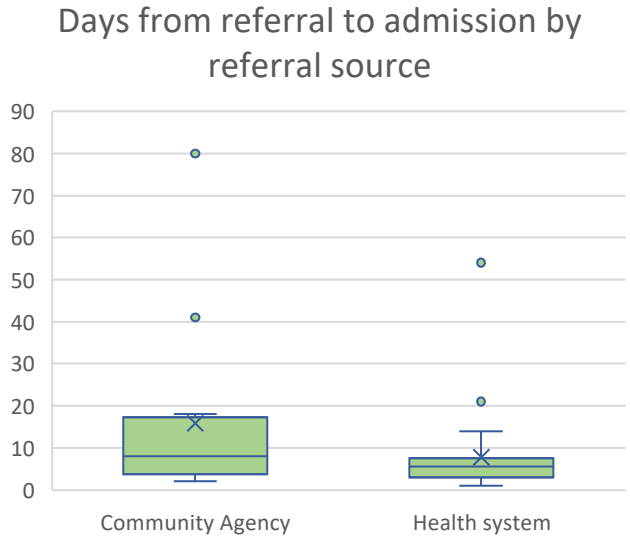
- Total referrals = 125
- Completed screenings = 87(70%)
- Resident admissions = 40 (32%)
- Average bed utilization rate = 77%

Referral Source	Referrals (N=125)	Accepted (N=40)	Direct hospital to MH
Health System	**89 (71%)**	**24 (27%)**	**20 (83%)**
Cleveland Clinic	34 (38%)	13 (38%)	13 (100%)
Metro Health System	29 (33%)	8 (27.5%)	4 (50%)
University Hospital	9 (10%)	2 (22%)	2 (100%)
St Vincent/Sisters of Charity	17 (19%)	1 (6%)	1 (100%)
Community Agency	**36 (29%)**	**16 (44%)**	**1 (3%)**

Time from referral to admission

- Median time from referral to admission* = 6 days (IQR 3 – 11 days)





*Data not available for all subjects. Missing values: Time from referral to admission = 1

Referrals: Not accepted

Reason Not Accepted (N=85)	n (%)
diverted	4 (4.7 %)
lost to follow up	26 (30.6%)
not eligible per admission criteria	38 (44.7%)
patient declined	14 (16.5%)
referral cancelled	3 (3.5%)

- No difference in reasons not accepted between health system referrals and community agency referrals
- Community agency referrals were more likely to be lost to follow up due to incomplete referrals or no show to health screening ($p=0.49^a$)

P-value: a=Fisher's Exact Test

Lost to Follow up Reasons (N=26)	n (%)
Incomplete referral	8 (30.8%)
Unable to reach	15 (57.7%)
Missed HCC appointment	3 (11.5%)
Not Eligible Reasons (N=38)	**n (%)**
Housed	10 (26.3)
No medical respite need	12 (31.6)
Needs higher LOC	13 (34.2)
Behavioral health	3 (7.9)

Residents: Characteristics

Demographics

- Age: Median 56 years (19-81 years)
- Race: White = 22(55%); Black 18(45%)
- Ethnicity: Hispanic/Latin(a/o/x) = 2(5%)
- Insurance (N=39)*:
  - Medicaid = 33(84.6%)
  - Medicare = 10(25.6%)
  - Private = 1(2.6%)
- Substance abuse history = 14(35%)
- Mental health history = 36(90%)
- Domestic violence history = 11(27.5%)

Housing History

- Chronic homeless = 9(22.5%)
- Shelter use* = 24(63/2%)
- Staying outside* = 18(48.6%)
- Eviction* = 13(34.2%)
- Living location prior to hospital or MH entry:
  - Shelter/outside = 17(42.5%)
  - Family/friend = 12(30%)
  - Home = 4(10%)
  - Motel = 3(7%)
  - Facility/Other = 4 (10%)

Residents from community referrals were more likely to have a history of domestic violence (p=0.01[a]) and staying outside (p=0.03[a])

P-value: a=Fisher's Exact Test. *Missing Data: insurance=1; shelter use=2; outside=3; eviction=2

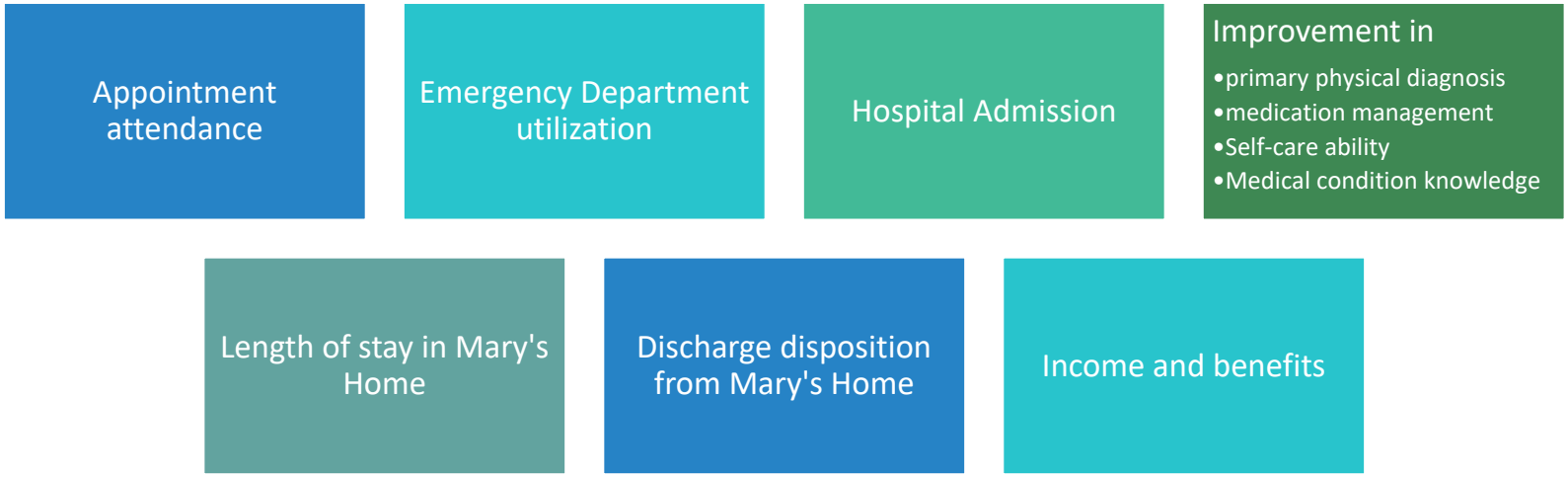
Coordination of care

Factor	Total (N=40)	Health system (N=24)	Community Agency (N=16)	p-value
Communication from referral source				0.50[a]
No	2 (5.0)	1 (4.2)	1 (6.3)	
Yes	37 (92.5)	23 (95.8)	14 (87.5)	
Missing	1 (2.5)	0 (0.00)	1 (6.3)	
Type of communication contact				**0.001[a]**
Phone Call	3 (9.7)	0 (0.00)	3 (30.0)	
Email	1 (3.2)	0 (0.00)	1 (10.0)	
Fax	26 (83.9)	21 (100.0)	5 (50.0)	
Meeting	1 (3.2)	0 (0.00)	1 (10.0)	

Statistics presented as N (column %). p-values: a=Fisher's Exact test.

- Community agencies were more likely to communicate with Mary's Home staff by phone, email, or meeting than Health System referrers.

Resident Outcomes



Resident Outcomes: Health

HEALTH CARE UTILIZATION

Factor (N=40)	n (%)
Primary Care Physician identified	32 (80.0%)
Attended follow up appointment (N=32)	17 (85%)
Behavioral health referral	15 (37.5%)
Attended BH appointment (N=15)	14 (93%)
Single Pharmacy retained/established	32 (80.0%)
Hospital admission	6 (15.4%)
ED visits* (N=34 residents)	17 (50%)
Decrease in ED utilization*	21 (61.7%)

*Determined using paired-t statistical tests and p-values: Wilcoxon Rank Sum test, Pearson's chi-square test, and Fisher's Exact test.

HEALTH RELATED IMPROVEMENT

Factor (N=39)	n (%)
Primary medical diagnosis	25 (64.1)
Medical management	30 (76.9)
Self-care ability	29 (74.4)
Knowledge of medical condition	32 (82.1)

- No differences in resident outcomes between black and white residents, or between health system and community referrals**

Resident Outcomes: Housing and income

HOUSING

Factor (N=40)	n (%)
Housing plan created within 2 weeks	30 (75%)
Discharge location	
Permanent housing	15 (38.5)
Nursing home	7 (17.9)
Temp housing	5 (12.8)
Hospital	6 (15.4)
Unknown/other	6 (15.4)

INCOME

Factor (N=40)	n (%)
Income improvement	
Less money	1 (2.5)
Same money	36 (90.0)
More money	3 (7.5)
Non-cash benefit obtained	3 (7.5)

- Median time spent at Mary's Home was 70 days (IQR=41-126 days)*
- No differences in outcome between race and referral source**

*Missing data for time at Mary's Home=5. **p-values: Wilcoxon Rank Sum test, Pearson's chi-square test, and Fisher's Exact test.

Resident Experience

- Transition from hospital to Mary's Home
- Collaboration between doctors, nurses, and MH staff
- Feelings of respect from healthcare providers
- Confidence in ability to manage medical condition after discharge

Transition from hospital to Mary's Home

Resident Survey Questions	Mean
My transition from the hospital to Mary's Home was clearly communicated to me. I knew that I had a room and when I would be discharged to Mary's Home.	4.13
When it was time for discharge from the hospital, transportation was readily available for me.	4.29
When I was discharged, I was provided with my medication and hospital paperwork	4.25
When I arrived at Mary's Home, staff were expecting me, and my room was ready.	4.75
When I arrived at Mary's Home, I was warmly welcomed and given a tour.	4.75

Staff and health care providers

Resident Survey Questions	Mean
My doctors, nurses, and Mary's Home staff worked together for my health care	4.25
I am respected by the staff and feel they are polite and kind	4.25
The staff at Joseph & Mary's Home recognize that I have strengths and skills as well as challenges and difficulties	4.00
My healthcare providers treated me with respect	4.50

Confidence in ability to manage medical condition after discharge

Resident Survey Questions	Mean
I understand my medical condition and treatment plan	4.25
I have confidence that I will be able to manage my medical care after I leave Joseph & Mary's Home	4.63

KEY TAKEAWAYS & OPPORTUNITIES

Process:

- Reduce erroneous referrals, increase diversion via health systems, other referring partners
- Reduce time to admission
- Calibrate length of stay expectations with expected resident outcomes

Resident Outcomes:

- Examine and improve array of service supports, as needed, relative to resident characteristics, conditions (e.g., DV survivor, SMI)
- Benchmark outcomes relative to similar MR programs around state, region and adjust performance goals, actions as needed
- Assure all have housing plan asap after admission or within 14 days

Resident Experience:

- Examine and further develop ongoing means for resident involvement in QA/QI

Administration:

- Improve data collection and recordkeeping

Beth Graham, Executive Director

Bethany.Graham@jmhome.org

(216) 363-7803

Erin Gay Miyoshi, Director of Fund Development

Erin.Miyoshi@jmhome.org

(216) 987-9201

JOSEPH & MARY'S HOME

A Ministry of the Sisters of Charity Health System

2412 COMMUNITY COLLEGE AVENUE, CLEVELAND, OH 44115 *jmhome.org*